HOOSIER ASSURANCE PLAN INSTRUMENT FOR CHILDREN & ADOLESCENTS

HAPI – C

SCORING INSTRUCTIONS

Developed by *Frederick L. Newman*, Florida International University

With:

John McGrew & Jeffrey Anderson
Indiana University Purdue University Indianapolis
Kathryn Vanderwater-Piercy
Professional Development Associates
Members of the HAPI-Child Advisory Committee

Project Director: *Richard DeLiberty*, Indiana Division of Mental Health
With: *Thomas Smith & Edward Ward*

TABLE OF CONTENTS

Hoosier Assurance Plan Instrument – Child: Training Packet

I. Overview & Values

The Hoosier Assurance Plan Instrument for Children and Adolescents [***HAPI-Child***] was developed to support the following program goal:

> ***To assure the child's age-appropriate development in terms of how well the child and the family, with the help of available resources, can support and strengthen the child's development and to minimize distress to the child, the family, and to the larger community system.***

Therefore the instrument is designed to achieve two assessment goals:

1. ***To assess the current status of the child's age-appropriate development in terms of how well the child and the family, with the help of available resources, can support and strengthen the child's development and to minimize distress to the child, the family, and to the larger community system.***
2. ***To provide an empirical basis for estimating the service costs to support and strengthen the child's age-appropriate development and to minimize distress to the child, the family, and to the larger community system.***

The Advisory committee set the following criteria for the initial development of the instrument:

1. The format should be as similar to that of the HAPI-Adult as possible.
2. The rating scale for each of the items should incorporate the concepts of self-management in daily functioning that underlie the HAPI-Adult scale, but should do so within the framework of strengthening the child's or adolescent's age-appropriate development and minimizing the distress to the child, the family, and to the larger community system.
3. The instrument for the first pilot study should attempt to cover all of the domains identified by the Advisory Panel to influence both outcome and program costs.
4. The outcome domains identified were:

Symptoms or distress	**Improving supports**	**Adjustment**
Mood/anxiety	Family	Social
Self-harm	School	Peer
Substance abuse	Community	Sexual
Life skills	**School level of function**	**Child/Family Caregiver Satisfaction**
Transition to adulthood	Peer	Services
Independence (IADL/ADL)	Aggression	Results of treatment
Educational/occupational readiness	Attention	Mood/anxiety
	Attendance	
	Grades	
	Behaviors	
	Problems and strengths	

5. The domains that were identified to influence costs were:

Community and home support/toxic environment	Sexual acting out	**Intensity of services**
Parental health	Self-abuse	Resources/supports available
Parental skills	Lack of support	Severity (Level of Function)
Peer relationships	School support	Need for support services (childcare, transportation, financial)
Substance use	**Problem behaviors**	
Abuse/neglect	Disruptive	**Attachment** (particularly in younger children)
Independence (Need for supervision)	Inappropriate	
ADL/IADL	Addictions	
Aggression	**Need for medications**	
	Psychotic symptoms	
	Depression	
	ADHD	

The advisory committee directed the research team to review the literature on assessment/outcome instruments for children. Fortunately, a recent publication (Bickman, Nurcombe, Townsend, Belle, Schut, & Karver, 1999; Consumer Measurement Systems for Child and Adolescent Mental Health) provided a detailed review of 188 instruments applying all of the criteria identified by the ***HAPI-C*** Advisory Committee. Moreover, Bickman and his colleagues provided a ranking of the instruments based upon the criteria, and the recommendation for the best core instrument was the *Ohio Youth Problems, Functioning, and Satisfaction Scales*, (Ogles, 1998) along with the recommendation that an acuity (severity of disorder) measure be added, and that the quality of life and quality of the parent-child relationship domains be improved. The review by Bickman and colleagues (1999) recommended specifically that the Family APGAR (scales include Adaptation, Partnership, Growth, Affection, and Resolve) and Students' Life Satisfaction Scale (SLSS) be added along with a "borrowed or built" acuity measure. The panel then instructed the research team to create an instrument that covered the domains of the Ohio and the APGAR instruments as well as the factors identified in the Indiana CAFAS mini-scale, but to do so within the format of the HAPI-Adult instrument.

II. Potential Applications

In addition to the criteria set forth by the panel, the design of the ***HAPI-Child*** has to meet the demands of two sets of applications. First, the instrument is expected to support local agency needs for assessment, service-treatment planning, and the review of the quality of care with and for the consumers of Indiana's system of services. Moreover, information recorded on the scale will be used to justify funding services for each child based upon a profile of her or his individual needs, and to follow the progress and outcome of the services.

The vocabulary of the scales within the instrument should also help communicate the status of the child with regard to service goals across staff disciplines and professional experiences, as well as among service agencies. This common vocabulary could help diminish the possibility for missed or miscommunication across agency and disciplinary lines. Such missed communication is thought to be related to a breakdown in the child's continuity of care and may lead to their dropping out of treatment.

Aggregate data from the instrument within and across agencies will be used:

a) to identify cost-homogeneous groups (children and adolescents with similar needs for services);
b) to justify level of reimbursement for each homogeneous cost group; and,
c) to provide a profile of children served and their outcomes.

III. Conceptual Framework for the Multi-Factor Instrument

Self-management as an organizing theme to rate functioning – Self-management can be better understood by examining and describing the impact that emotional and behavioral needs have on a child's functioning. The ***HAPI-C*** provides a continuum of ratings from nonexistent to extreme. At one end, when self-management is operating very well (*minimal* difficulty with managing the problem and its impact on functioning) the child is capable of monitoring her/his reactions to stressful situations and managing her/his symptoms. When these symptoms appear to be stressful and/or become problematic to role performance or functioning, the child may be given or make use of available resources and supports (e.g., family members, caregivers, teachers, peers) to mitigate the problem or its potential negative influence on role functioning. Progressing further along the continuum, the child increasingly needs support and/or external resources to adequately self-manage (*moderate* levels). At the extreme end of the continuum, problems are so *severe* that the child will need significant support or resources for their management, and even with interventions, may not be able to adequately maintain behaviors similar to same age peers who do not have emotional or behavioral challenges.

The manner in which self-management skills are manifested is largely determined by the nature of the problem and its potential impact on role performance or functioning. Additionally, raters should use typical age behavior as their reference point when making each rating judgment. In other words, to what degree is the child's functioning different from the average or typical functioning of peers the same age who do not have special needs.

The family's self-management skills can also be described in a fashion that parallels that of the child. However, the family's focus is on their ability to manage their support of the child's age-appropriate development, or their support of the child's ability to manage or moderate the impact that the child's emotional disturbance may have on her or his functioning. The ratings for the family's management of their support of the child follows the same guidelines for determining levels as described for the child, going from minimal, to moderate, to severe problem difficulty or impact on functioning.

The definitions of each rating level given within each item are different because the features of each problem area and the self-management skills needed to cope with the problem are specific to that domain. Therefore, be sure to refer to the definition of the level within each item. The items within the ***HAPI-C*** instrument are grouped by factors, and their content is intended to cover the following domains:

Factor(s)	***Domains Covered by the HAPI-Child Instrument***	***Item # on HAPI-C***	***Pages in Scoring Instructions***
A, B	Symptoms of Distress, Mood, & Suicidal or Self Injurious Behavior	**1-4**	**11**
C, D	Signs of Abuse and Neglect	**5-6**	**12**
E	Health and Physical Status of Child	**7**	**13**
F	Thinking	**8-9**	**14-15**
G	Family Functioning and Support	**10-12**	**16-19**
H	School Performance, Achievement, and Peer/Classmate Interactions	**13-16**	**20-23**
I	Disruptive Behavior	**17-19**	**24-26**
J, K	Substance Use/Abuse and Tobacco Use	**20-23**	**27-28**
L	Reliance on Mental Health Services	**24**	**29**

IV. Gathering Evidence to Complete the HAPI-C

The evidence needed to complete the ***HAPI-C*** will probably come from a number of different sources, but a major information source will be information collected during an interview with the child and/or the parent(s)/caregiver(s). Although this section focuses on methods for collecting data during the interview with the child and/or the parent(s)/caregiver(s), information from other sources (teachers, school administrators, social service personnel, juvenile justice personnel) should be considered where appropriate.

Conducting the interview – The principle guideline in completing the instrument is that gathering the information needed from an interview with the child and/or the parent(s)/caregiver(s) should not interfere with the flow of the clinical interview. The interviewer's interactions with the child or family members (caregivers) should not be interrupted by artificial questions that interfere with learning about the child's circumstances. Thus, all questions asked should be framed in a manner that supports the telling of their story. The child or parent(s)/caregiver(s) should expect that you will both attend to them and that you will accurately record the information they are providing you.

Using and tailoring the recommended probe questions – Each item has a question that can be used to initiate discussion with the child and/or parent(s)/caregiver(s) on that topic. You do not need to use the exact wording of the *probe* question. Consider the *probe* question to be a *recommended* line of inquiry and an opening question that would lead the person or persons being interviewed to provide the evidence needed to arrive at a rating. Attending to the disposition of the child at the time of the interview and the tone of the relationship that you have established with the child and/or parent(s)/caregiver(s) should guide how the question ought to be framed.

Order of the probe questions is recommended but not required – Although the sequence of the *probe* questions is recommended, the actual sequence you employ should be tailored to what the child or parent(s)/caregiver(s) brings into the interview. The most important guide is how the sequence, content, and tone of the questions support a relationship such that the child or parent(s)/caregiver(s) is willing to help you to help them. While it is important that all the major areas are covered, sticking strictly to the listed sequence is not required.

Providing evidence for a rating – You will need to give ratings and then offer evidence, either on the form or in a clinical narrative, to support the ratings that are equal to or less than , in a manner that is dictated by your agency's policies. This will be important for both communicating with colleagues and for auditing the records. The ratings provide a translation of what you observe or information you have gathered about the child or parent(s)/caregiver(s). Thus, it will be important that you provide examples of observations, or the evidence that was available that led to each rating. Behaviors typical to each item are given below the *probe* question. These are to be seen as guidelines to the behaviors that are often observed under that behavioral domain. The list is not necessarily exhaustive. In any event, you are to provide evidence unique to that child or parent(s)/caregiver(s) that supports the rating. If evidence came from sources other than the child or the parent(s)/caregiver(s), cite the source of the information.

Corroborating self-report information, and what to do with conflicting evidence – Much of the evidence you obtain for this instrument is self-report from the child, from parents, or from caregivers. It is possible that there will be conflicting views of what the "facts" are from these different sources. It is often useful to seek corroborating evidence from teachers or school administrators, and from representatives of

the juvenile justice system if the child has been involved with this system. Even then it may not be possible to determine what is the "truth". Here, a clinical judgment must be made as to which "facts" to use in making the rating on each item, but the basis for that judgment should be noted in the clinical narrative.

Learn the conceptual framework and vocabulary of the instrument – The instrument represents a common frame of reference for communicating symptoms and problem severity, self-management skills, and the impact of these on community functioning among three classes of people: a) those providing services to the child; b) the child; and, c) those in the child's support system. Moreover, the instrument has also been developed to reflect the service system's values and philosophy. Here it is worthwhile to summarize earlier discussions.

- ***The definitions of the levels within each item are related to the instrument's common themes*** – The primary goal of the service system is to assure the child's age-appropriate development in terms of how well the child and the family, with the help of available resources, can support and strengthen the child's development and to minimize distress to the child, the family, and to the larger community system. Each item of the scale seeks to estimate the degree to which a particular problem or deficit impacts on the child's age-appropriate daily functioning and is mitigated by her/his ability to self-manage. Thus, the definitions of the levels within each item are the primary references when rating a single item.

- ***Drawing together symptom and problem severity with self-management skills*** – Severe symptoms are correlated with increased psychological distress, impaired community and interpersonal functioning, and difficulty participating positively in treatment. As symptom severity decreases and social skills increase, the person is better able to become involved in and/or manage their own treatment. The choices for a rating on each of the items within the ***HAPI-C*** are defined in terms of how symptom or problem severity combines with a child's or family member's self-management skills to impact on the child's functioning and/or development. The overview of the development of all of the ***HAPI-C*** items is described on the back cover of this training manual.

- ***Using the language of the instrument to communicate*** – The vocabulary across items is also designed to help you communicate the status of the child with regard to service goals. It is a vocabulary that is intended to bridge differences in disciplines, agency affiliation, and experience. This common vocabulary could help diminish the possibility for missed communication across agency and disciplinary lines. Such missed communication is thought to be related to a breakdown in the child's continuity of care and her/his eventually dropping out of treatment. By using the consistent language of the instrument's common themes (to minimize distress and to promote self-management) the likelihood of missed communication should be diminished.

- ***Using the instrument to assess children with possible substance abuse problems (as a single or a co-morbid condition)*** – The instrument covers all of the major areas covered under standardized substance abuse instruments, but uses a format that is consistent with the values stated earlier. Although there is an item that focuses specifically on substance abuse, ratings on other items may be influenced by the child's use of alcohol or drugs. These items are:
  #18. Disruptive & Inappropriate Behavior
  #19. Risk or Criminal Behavior

#24. Reliance on Mental Health Services

For each of these items, there is a *check box* that allows the rater to indicate that the problem is associated with substance use. If this choice is made as evidence supporting the severity rating, it is necessary to indicate the issues related to substance use. It is recognized that substance use also may influence ratings for other items. You can document this by providing notes either in the space provided on the form or in the clinical narrative (as dictated by your agency's policies). Under item **#19**, **Risk or Criminal Behavior**, there are several check boxes that may be related to substance use. Be sure to provide notes if any of these are checked.

Additional notes are provided for the substance abuse items **(#20, #21, and #22)** and the tobacco use item **(#23)** in the training manual.

Normal behavior is the over-riding frame of reference – When rating a child or parent(s)/caregiver(s), consider the child's or parent(s)/caregiver(s)' behaviors relative to those of a typical child without a mental health challenge (or parent/caregiver) of similar age, gender, and socio-economic status.

V. Overview of Instructions on Completing the Instrument

Scoring the *HAPI-Child*: A score ranging from ① to ⑦ is required for each item on the instrument. A rating of ① indicates that there is evidence of a problem having the most severe impact on the child's functioning or the parents'/caregivers' support of the child's functioning and/or development in that area, and that it is beyond the capability of the child or parent(s)/caregiver(s) to manage its negative impact. A rating of ⑦ indicates that the evidence is that there is no problem of self-management or impact on functioning and/or development in this area. If the interviewing clinician finds that the available information is so weak that she or he has *low confidence* **(LC)** in a rating, then both **LC** and an estimated rating level on the ① to ⑦ scale should be marked. Stated another way, the interviewing clinician should attempt to gather whatever information is available from the child or from an informant to make the rating, and if still unsure that the rating is accurate, indicate this by marking **LC** plus an estimate of the rating. The guiding principles for making the ratings are given on the back cover of this training manual. The specific details for rating each item are given in the next section of the manual.

***Ratings within each item* -** Detailed definitions are given below. There are two choices within each item that have the same definition throughout.

○**-LC** = Low Confidence. Please make every effort to gather information sufficient to give a reasonable estimate of a rating for all items. If you are uncertain of the rating on a particular item, provide the rating anyway, but indicate that you are still uncertain by checking the ○**-LC** rating plus a rating of your best guess of the right level for that item. If no information is available for an item, mark **LC** plus the rating most typical of other similar items for which you did make a rating based upon available evidence.

⑦ **= None.** This rating is marked if there is evidence that there are no signs of a problem within the domain covered by that item. One would need evidence that no problem exists and that the child or parent(s)/caregiver(s) is capable of managing functioning in this area.

***Factor A: Affective Symptoms (Items 1, 2 & 3) and Factor B: Suicide Ideation/Behaviors (Item 4)*:** The first four items have similar descriptions of ratings of symptomatic distress and impact on functioning. If the level of symptomatic distress threatens to interfere with day-to-day functioning, then the clinical interviewer is expected to determine if signs of anxiety, depression, and/or suicidal thoughts/actions accompany the distress. Other signs of distress, such as having an eating disorder, can be included here and, if appropriate, can be noted as a sign of anxiety or depression. Ratings of distress (Item **#1**), anxiety - worry (Item **#2**), depression (Item **#3**), and suicidal and/or self-injurious thoughts/actions (Item **#4**) have a similar logic in the sequence of rating choices as follows:

- ⑤ *Minimal Difficulty (Distress, Anxiety, Depression, Suicidal or Self-Injurious Thoughts/Actions)* – Symptoms controlled with effort

At level symptoms are noticeably present some of the time, but the threat to role performance or functioning is readily controlled by the child.

At level ⑤ the symptoms are more consistently present and clearly recognized. To prevent noticeable impairment to role performance or functioning, the child exerts consistent vigilance and effort to deal with the distress.

④ - ③ *Moderate Difficulty (Distress, Anxiety, Depression, or Suicidal or Self-Injurious Thoughts/Actions*) – Moderates symptoms' impact on functioning with extra effort and support

At level ④ symptoms do impair role performance or functioning to a degree that is readily noticeable to child or others. The child can moderate the impact of the symptoms with extra effort and with support from others when the level of distress starts to become overwhelming.

At level ③ symptoms are sufficiently active to impair role performance or functioning below a level acceptable to the child or others in contact with the child. The support needed from others to moderate the impact of the symptoms is greater than that needed to support a level 4 rating, and is welcomed and seen by the child and/or caregivers as necessary to perform day-to-day functions.

② - ① *Severe Difficulty (Distress, Anxiety, Depression, Suicidal or Self-Injurious Thoughts/Actions)* – Does not control symptoms, close supervision required to function

At level ② the symptoms are consistently present and overwhelming to the child such that she or he can attend to little else, but will respond to efforts by others to provide assistance (support or treatment).

At level ① the symptoms are at least as debilitating as level ②, however, the child is so overwhelmed by the symptoms that they are either uncooperative with efforts to help them, are indifferent to such efforts, or are so debilitated by the symptoms that they are simply unable to help themselves.

For Item **#1**, indicate who is providing the information to determine the rating of the child's level of distress. This could be the child, a parent, or another caregiver. Be specific (e.g., biological mother, aunt, foster parent, and so forth).

Factor C: Abuse (Item 5) and Factor D: Neglect (Item 6)*:** Evidence of ***abuse indicates that the child has been physically, sexually or emotionally abused during the last 30 days such that the child's safety, well-being or development has been threatened. Evidence of ***neglect*** indicates that the child has been neglected in ways that threaten the child's safety, well-being or development.

For each of Items **#5** and **#6**, indicate the parent or caregiver being rated for a level of abuse or neglect below a value of "**7**". Be specific (e.g., biological mother, aunt, foster parent, and so forth).

The possible ratings for each of these single item Factors are:

- ⑤ *Minimal Difficulty* – Avoids impact or manages with effort

At level signs of abuse or neglect are evident but the threat to role performance or functioning is readily controlled by the child, either because of the mildness of the abuse or neglect, or because of the capability of the child to avoid or tolerate the impact of the abuse or neglect.

At level ⑤ the signs of abuse or neglect are more consistently present and clearly recognized by the child. To prevent noticeable impairment to role performance or functioning, the child exerts consistent vigilance and effort to deal with the abuse or neglect.

④ - ③ *Moderate Difficulty* – Abuse's or neglect's impact on functioning moderated with extra effort and support

At level ④ signs of abuse or neglect are more consistently evident and do impair role performance or functioning to a degree that is readily noticeable to the child or others. The child can avoid or tolerate the abuse or neglect and thereby moderate its impact on functioning, but only with extra effort and with support from others when the level of abuse or neglect starts to become overwhelming.

At level ③ signs of abuse or neglect are more frequent and are sufficiently intense to impair role performance or functioning below a level acceptable to the child or others in contact with the child. The support needed from others to moderate symptom impact on functioning is greater than that needed to support a level 4 rating, and is welcomed and seen by the child as necessary to perform day-to-day functions.

② - ① *Severe Difficulty* – Severe impact on functioning, requires close supervision and support

At level ② the signs of abuse or neglect are consistently present and overwhelming to the child such that she or he can only function with efforts by others to provide assistance (support or treatment), which the child readily accepts.

At level ① the signs of abuse or neglect are consistently present, and are at least as debilitating as Level ②, however, the child is (or has been) so overwhelmed by the abuse or neglect that they are either uncooperative with efforts to help them, are indifferent to such efforts, or are so debilitated by the abuse or neglect that they are simply unable to help themselves.

***Factor E: Health/Physical Status (Item 7)*:** The child may have one or more medical or physical conditions that can impact role performance or functioning independent of any emotional or behavioral problems (and *vice versa*). It is also possible that there are significant interactions between the child's medical or physical condition and her/his mental health or addiction status. You are to describe whether there is any medical or physical condition that could interfere with functioning, and if so to what degree the condition impacts on their ability to manage their role or functioning. It will be important to identify one or more medical or physical conditions and the extent to which it is chronic or acute. NOTE, if it is a female, identify whether or not she is pregnant.

- ⑤ *Minimal Difficulty* – Manages daily activities with effort

At level the impact of the physical or health problem on functioning is noticeable some of the time, but the child is able to control any threat to role performance or functioning.

At level ⑤ impact of the physical or health problem on functioning is more consistently present and noticeable such that to minimize negative impact the child exerts consistent vigilance and effort to function in an appropriate manner.

④ - ③ *Moderate Difficulty* – Moderates impact on functioning with extra effort and support

At level ④ difficulty with performing activities is noticeable to the child or others, but the child can moderate the impact of the physical or health problem on functioning with extra effort and support from others. The child recognizes what resources are needed to sustain role performance and functioning and will seek assistance from others.

At level ③ difficulty to perform activities is at a level that would lead to negative consequences without direct help from others. The support needed from others is welcomed by the child and is seen as necessary to perform these activities. It is the level of dependency on assistance from others that distinguishes level ③ from ④. At level ③ others, and not the child, take the major responsibility for managing resources to moderate the impact of the physical or health problem to sustain role performance or functioning.

② - ① *Severe Difficulty* – Severe impact on functioning, requires continued supervision and support

At level ②, performing activities impacted by the physical or health problem is beyond the capability of the child, but she/he does recognize the negative consequences of the problem if left unattended. Thus, she/he will permit others to assist directly in her/his activities.

At level ① performing activities impacted by the physical or health problem is beyond the capability of the child. The child does not recognize the consequences of not attending to the condition adequately, and either resists any assistance by others or is so indifferent to any assistance that she/he lacks the understanding that the intervention could remedy the problem.

Factor F: Thinking (Item 8 – Time - Task Orientation &/or Completing Assigned Tasks): This item focuses on the child's activities outside of school, mostly in the home and neighborhood. At issue is the degree to which the child is able to manage difficulties with time and task orientation, and/or completion of those tasks required of day-to-day functioning in the home or the community.

- ⑤ *Minimal Difficulty* – Compensates with effort

At level the child's difficulty with time-task orientation and/or completing assigned tasks is noticeable some of the time, but the child is able to easily control any threat to performance or is able to complete the task.

At level ⑤ the child's difficulty with time-task orientation and/or completing assigned tasks is more consistently present and recognized by the child. To prevent noticeable performance impairment she/he exerts consistent vigilance and effort.

④ - ③ *Moderate Difficulty* – Moderates impact on functioning with extra effort and support

At level ④ the child's difficulty with time-task orientation and/or completing assigned tasks is noticeable to the child and others, but she/he can perform these activities with extra effort and support from others. The child can (does) take an active role in the appropriate use of these supports to perform or to complete assigned tasks in the home or community environment.

At level ③ the child's difficulty with time-task orientation and/or completing assigned tasks is at a level that would lead to negative consequences without direct help from others. The support needed from others is welcomed by the child and is seen as necessary to perform these activities. In the child's home or community environments, others, and not the child, take the major responsibility in helping to direct and monitor the performance of tasks.

② - ① *Severe Difficulty* – Does not compensate, intervention required

At level ② ability to compensate for difficulties in time-task orientation and/or completion of tasks appears to be beyond the capability of the child, but in realizing the negative consequences the child accepts and will permit others to supervise her/his activities very closely.

At level ① ability to compensate for difficulties in time-task orientation and/or completion of tasks is beyond the capability of the child. The child may not see this as a problem and either resists any assistance by others or is so indifferent to any assistance that she/he exhibits no belief or understanding that any assistance could correct the problem.

***Factor F: Thinking (Item 9 – Problem Solving)*:** The focus is on the child's ability to manage difficulties in problem solving, including calling upon others for assistance, in the home, neighborhood, or community environments.

- ⑤ *Minimal Difficulty* – Problem solving done with effort

At level difficulty in problem solving is noticeable some of the time, but the child is able to easily control any threat to impaired performance.

At level ⑤ difficulty in problem solving is more consistently present and recognized by the child. To prevent noticeable performance impairment the child exerts consistent vigilance and effort.

④ - ③ *Moderate Difficulty* – Problem solving done only with extra effort and support

At level ④ difficulty in problem solving is noticeable to the child or others, but she/he can moderate the impact to perform these activities with extra effort and support from others. The child takes an active role in the appropriate use of these supports to do the problem solving.

At level ③ difficulty in problem solving is at a level that would lead to negative consequences without direct help from others. The support needed from others is welcomed by the child and is seen as necessary to perform these activities. In the home and community environment, others, and not the child, take the major responsibility in helping to direct and monitor problem solving.

② - ① *Severe Difficulty* – Unable to problem solve, requires close supervision

At level ② problem solving appears to be beyond the capability of the child, but in realizing the negative consequences the child will permit others to supervise her/his activities very closely.

At level ① problem solving is beyond the capability of the child. The child may not see this as a problem and either resists any assistance by others, or is so indifferent to any assistance that the child lacks the understanding that any assistance could correct the problem.

Factor G: Introduction to Parent/Caregiver Assessment (Items 10 – 12)

Items that assess parent or caregiver functioning require the rater to focus on the parent(s) or caregiver(s) who are expected to eventually assume the permanent parental/caregiver role by the end of treatment. Identifying the family or caregiver(s) who fit this role is not always clear, and the variety of different circumstances require the clinical assessor to use some judgment (often in consultation with a clinical supervisor, colleagues and/or representatives from social services or the criminal justice programs). Whenever possible, it should be the biological parents who are the focus of these ratings because there is a treatment goal of family preservation. Even when it may not be possible to identify an intact biological family unit, a specific foster family should be identified, although the goal of family preservation still may not necessarily be ruled out. There are, of course, a large number of other possibilities:

- Foster care, with one or more parents requiring long term physical, mental health or substance abuse treatment, or who are incarcerated such that the biological parent(s) will not assume a parenting role for many years.
- Same as above, but the biological parents probably can and will resume their parenting role, but not for at least 12 months.
- Parent/Caregiver is the focus, but short or long-term physical, mental health or substance abuse treatment for one or more members of the family will need to be included with the treatment plan for the child.

In all of the above cases, the ratings would still focus on the biological parent(s) as the eventual intended permanent caregiver. In addition all ratings should focus primarily on the family (or caregiver) functioning (as a unit), which is expected to support the child's age appropriate development. For this factor, you are asked to identify the *Assumed Parent(s)/Caregiver(s) being rated.* Be specific as to the parent/caregiver that is assumed to be the eventual intended permanent caregiver. Some of the possibilities include a single mother, single father, or married biological parents, stepparents, or one biological and one stepparent (married), single or married foster parents, and so forth.

***Factor G: Family (Item 10 – Parental/Caregiver Support of the Child's Growth)*:** The focus here is on the parent's or caregiver's ability to support the child's growth by communicating with the child about her/his needs or concerns, or by encouraging the child to try new things. Signs of difficulty include the parent's/caregiver's inability to effectively communicate with the child or to recognize that change or growth is possible or desirable. Another sign may be that the parent's/caregiver's own health, physical, or psychological status may inhibit such support.

- ⑤ *Minimal Difficulty* – Parent(s)/Caregiver(s) supports growth with effort

At level the parent's or caregiver's difficulties in supporting the child's growth are noticeable some of the time, but the parent or caregiver is able to easily control any threat to the child's growth and development. It is also possible that the health, physical, or psychological status of a parent(s) or caregiver(s) may impact their ability to support the child's growth, but this is readily recognized and controlled by the parent(s) or caregiver(s).

At level ⑤ the parent's or caregiver's difficulties in supporting the child's growth are more consistently present and recognized. To prevent noticeable impact on growth, the parent(s) or caregiver(s) exert consistent vigilance and effort. It is also possible that the health, physical, or psychological status of a parent(s) or caregiver(s) may impact their ability to support the child's growth, but this is readily recognized and controlled by the parent(s) or caregiver(s) with vigilance and effort.

④ - ③ *Moderate Difficulty* – Parent(s)/Caregiver(s) support for growth limited, requires extra effort and support

At level ④ the parent's or the caregiver's can support the child's growth only with extra effort and support from others. The parent(s) or caregiver(s) take an active role in the appropriate use of these supports in order to facilitate the parent's or caregiver's ability to support the child's growth.

At level ③ the parent's or the caregiver's capacity to support the child's growth is at a level that would lead to inhibiting the child's growth without direct help from others. The support needed by the parent(s) or the caregiver(s) from others is welcomed by the parent(s)/caregiver(s) and is seen as necessary in order to moderate the potential negative impact on growth.

② - ① *Severe Difficulty* – Parent(s)/Caregiver(s) does not support growth without supervision

At level ② the parent's/caregiver's capability to take responsibility for supporting the child's growth appears to be beyond their control, but in realizing the negative consequences they will permit others to supervise or oversee their activities very closely.

At level ① taking responsibility for participating in such activities is beyond the capability of the parent(s)/caregiver(s). The parent(s)/caregiver(s) may not see this as a problem and is either resistant to any assistance by others or is so indifferent to any assistance that they exhibit no belief or understanding that any assistance could correct the problem.

***Factor G: Family (Item 11 – Parent/Caregiver Sharing of Time/Resources & Interacting with Affection and Care)*:** The focus is on the parent's/caregiver's ability to share their own time and their personal resources with the child and with each other in a fashion that demonstrates affection and caring for the child. A typical source of difficulty may be that the parent's or caregiver's own health, physical, or psychological status may inhibit such sharing or inhibit the expression of affection and caring. Another source of difficulty may be that there has been a long standing approach to interactions with the child or that involves blaming, so there is a history of not expressing oneself to the child with affection and caring.

- ⑤ *Minimal Difficulty* – Parent(s)/Caregiver(s) shares time/resources with the child and interacts with affection/caring with some effort

At level the parent's/caregiver's difficulties in sharing or expressions of affection and caring are noticeable some of the time, but the parent/caregiver is able to easily control any threat to the child's growth and development. It is also possible that the physical or mental health status of a parent(s)/caregiver(s) may impact their ability to provide such sharing or expressions of affection and caring, but this is readily recognized and controlled by the parent(s) or caregiver(s).

At level ⑤ the parent's/caregiver's difficulties in sharing or expressions of affection and caring are more consistently present and recognized. To prevent noticeable impact on the child's functioning, the parent(s)/caregiver(s) exerts consistent vigilance and effort. It is also possible that the physical or mental health status of a parent(s)/caregiver(s) may impact their ability to provide such sharing or expressions of affection and caring, but this is readily recognized and controlled by the parent(s)/caregiver(s) with vigilance and effort.

④ - ③ *Moderate Difficulty* – Parent(s)/Caregiver(s) requires extra effort & support to share time/resources with the child and interact with affection/caring

At level ④ the parent's/caregiver's sharing and expressions of affection and caring is only done with extra effort and support from others. The parent(s)/caregiver(s) take an active role in the appropriate use of these supports to facilitate their ability to share and display affection to support the child's functioning and/or growth.

At level ③ the parent's/caregiver's capacity to share and express affection and caring is at a level that would lead to inhibiting the child's growth without direct help from others. The support needed by the parent(s)/caregiver(s) from others is welcomed by the parent(s)/caregiver(s) and is seen as necessary in order to moderate the potential negative impact on the child's functioning and/or development.

② - ① *Severe Difficulty* – Parent(s)/Caregiver(s) cannot share time/resources with the child and interact with affection/caring without supervision

At level ② the parent's/caregiver's capability to share and express affection and caring appears to be beyond their control, but in realizing the negative consequences they will permit others to supervise or oversee their activities very closely.

At level ① taking responsibility for sharing and expressing feelings of affection and caring is beyond the capability of the parent(s)/caregiver(s). The parent(s)/caregiver(s) may not see this as a problem and either resists any assistance by others or is so indifferent to any assistance that they exhibit no belief or understanding that any assistance could correct the problem.

***Factor G: Family (Item 12 – Effects of Child's Behavior on Family and Family Interactions)*:** This item focuses on the effects of the child's behavior on parent's/caregiver's functioning and the relationships among members of the household. Often this is manifested in members of the household blaming each other for the child's behaviors, or resenting the time, effort and expense consumed by the child's emotional disturbance.

- ⑤ *Minimal Difficulty* – Impact of child's behavior on the family managed with effort

At level the impact of the child's behavior on the interactions and relationships among members of the household is noticeable some of the time, but the parent(s)/caregivers are able to easily control any threat to their day-to-day interactions and relationships.

At level ⑤ the impact of the child's behavior on the interactions and relationships among members of the household is more consistently present and recognized. To prevent noticeable negative impact on their interactions and relationships, parent(s)/caregiver(s) exert consistent vigilance and effort.

④ - ③ *Moderate Difficulty* – Impact of child's behavior on the family is moderated with extra effort and support

At level ④ the parent's/caregiver's can moderate the impact of the child's behavior on the interactions and relationships among members of the household only with extra effort and support from others. The parent(s)/caregiver(s) take an active role in the appropriate use of these supports to moderate the impact of the child's behavior.

At level ③ the impact of the child's behavior is at a level that negative interactions occur with some frequency and would get worse without direct help from others. The support needed by the parent(s)/caregiver(s) from others is welcomed by the parent(s)/caregiver(s) and is seen as necessary in order to moderate further negative impact on family relationships.

② - ① *Severe Difficulty* – Parent(s)/Caregiver(s) copes with child's behavior only with supervision

At level ② the parent's/caregiver's capability to take responsibility for dealing with the negative impact of the child's behaviors on their interactions and relationships appears to be beyond their control, but in realizing the negative consequences they will permit others to supervise or oversee their activities very closely.

At level ① taking responsibility for dealing with the negative impact of the child's behavior is beyond the capability of the parent(s)/caregiver(s). The parent(s)/caregiver(s) may not see this as a problem and either resists any assistance by others or is so indifferent to assistance that they do not recognize that assistance could correct or reduce the problem.

***Factor H: School (Item 13 – School Support)*:** This item focuses on the child's need for special resources or services to attend classes. The resources may include physical access aids, tutors, special education services, paraprofessionals or aides, or emotional/behavioral control procedures such as behavior management plans. These should be noted in the narrative.

⑦ ***No Services Needed to Maintain Functioning at School***

At level ⑦, services are not needed.

- ⑤ *Minimal Difficulty Without Services* – Can manage with effort

At level the child will manifest some sub-optimal functioning in school without services.

At level ⑤ the child will manifest mild impairment in at least one major school area without services.

④ - ③ *Moderate Difficulty Without Services* – Can manage with extra effort and support

At level ④ the child will manifest moderate difficulty in at least one major school area without services.

At level ③ the child will manifest moderate difficulty in more than one major school area without services.

② - ① *Severe Difficulty Without Services* – Cannot manage without supervision or support

At level ②the child will manifest severe difficulty in at least one major school area such that complete failure appears to be imminent without services.

At level ① the child will manifest severe difficulty in multiple school areas such that complete failure in multiple areas appears to be imminent without services.

***Factor H: School (Item 14 – School Achievement)*:** This item focuses on the child's ability to academically achieve in a regular classroom at an age appropriate level. Detraction from such achievement could be due to hyperactivity or inattentive behavior, as if bored. The teacher will often express concern that the child is not meeting her or his expectations.

- ⑤ *Minimal Difficulty* – Meets expectations with effort

At level difficulty with academic achievement is noticeable some of the time, but the child is able to easily control any threat to impaired performance.

At level ⑤ difficulty with academic achievement is more consistently present and recognized. To prevent noticeable performance impairment the child exerts consistent vigilance and effort.

④ - ③ *Moderate Difficulty* –Meets expectations with extra effort and support

At level ④ difficulty with academic achievement is noticeable to self or others, but the child meets expectations with extra effort and support from others. The child takes an active role in the appropriate use of these supports to meet academic expectations.

At level ③ difficulty with academic achievement is at a level that would lead to negative consequences without direct help from others. The support needed from others to meet expectations is welcomed, and is seen as necessary by the child.

② - ① *Severe Difficulty* – Does not meet expectations without supervision

At level ② the child's ability to take responsibility to meet academic expectations appears to be beyond her/his capability, but in realizing the negative consequences she/he will permit others to supervise her/his activities very closely.

At level ① the child's ability to take responsibility to meet academic expectations is beyond her/his capability. The child may not see this as a problem and either resists any assistance by others or is so indifferent to any assistance that she/he exhibits no belief or understanding that any assistance could correct the problem.

***Factor H: School (Item 15 – Interactions with Classmates & Peers)*:** This item focuses on the child's ability to interact with classmates in class and other school related activities, as well as with peers in the neighborhood and community. The emphasis of the rating is on the behaviors that the child exhibits as she/he interacts with classmates and peers, e.g., shyness or withdrawal, aggressiveness, refusal to interact, or inappropriate behavior.

- ⑤ *Minimal Difficulty* – Interacts with classmates & peers with effort

At level difficulty in interactions with classmates and peers is noticeable some of the time, but the child is able to easily control any threat to the civility, frequency, apparent skillfulness or appropriateness of her or his interactions.

At level ⑤ difficulty in interactions with classmates and peers is more consistently present and recognized. To prevent noticeable impact on the child's functioning, the child exerts consistent vigilance and effort.

④ - ③ *Moderate Difficulty* – Moderates difficulty in interactions with classmates & peers with extra effort and support

At level ④ the child is able to moderate difficulty in her/his interactions with classmates and peers only with extra effort and support from others. The child takes an active role in the appropriate use of these supports to moderate the difficulty in interactions between the child and classmates or peers.

At level ③ the child's ability to interact positively with classmates and peers is sufficiently impaired that the frequency of inappropriate interactions would increase and would lead to negative consequences without direct help from others. The support needed from others is welcomed by the child and is seen as necessary in order to moderate the potential negative impact on the child's interpersonal relationships with classmates or peers.

② - ① *Severe Difficulty* – Unable to interact successfully without supervision

At level ② the child's ability to take responsibility for her/his interactions with classmates and peers appears to be beyond her or his control, but in realizing the negative consequences she/he will permit others to supervise or oversee these interactions very closely.

At level ① the child's ability to take responsibility for her/his interactions with classmates and peers is beyond her or his capability. The child may not see this as a problem and either resists any assistance by others or is so indifferent to any assistance that she/he exhibits no belief or understanding that any assistance could correct the problem.

***Factor H: School (Item 16 – Interactions with Teachers & Administrators)*:** This item focuses on the child's ability to interact with teachers and administrators in class and other school related activities. The emphasis of the rating is on the behaviors that the child exhibits as she/he interacts with teachers and administrators, e.g., shyness or withdrawal, aggressiveness, refusal to interact, or acts in inappropriate ways.

- ⑤ *Minimal Difficulty* – Interacts with teachers & administrators with effort

At level difficulty in interactions with teachers and administrators is noticeable some of the time, but the child is able to easily control any threat to the civility, frequency, apparent skillfulness or appropriateness of her/his interactions.

At level ⑤ difficulty in interactions with teachers and administrators is more consistently present and recognized. To prevent noticeable impact on the child's functioning, the child exerts consistent vigilance and effort.

④ - ③ *Moderate Difficulty* – Moderates difficulty in interactions with teachers & administrators with extra effort and support

At level ④ the child can moderate difficulty in her/his interactions with teachers and administrators only with extra effort and support from others. The child takes an active role in the appropriate use of these supports to moderate interactions with teachers and administrators.

At level ③ the child's ability to interact positively with teachers and administrators is sufficiently impaired that the frequency of inappropriate interactions would increase and would lead to negative consequences without direct help from others. The support needed from others is welcomed by the child and is seen as necessary in order to moderate the potential negative impact on the child's interpersonal relationships with teachers and administrators.

② - ① *Severe Difficulty* – Unable to interact successfully without supervision

At level ② the child's ability to take responsibility for her/his interactions with teachers and administrators appears to be beyond her/his control, but in realizing the negative consequences she/he will permit others to supervise or oversee these interactions very closely.

At level ① the child's ability to take responsibility for her/his interactions with teachers and administrators is beyond her/his capability. The child may not see this as a problem and either resists any assistance by others or is so indifferent to any assistance that she/he exhibits no belief or understanding that any assistance could correct the problem.

Factor I: Disruptive Behavior (Item 17 – Negative Peer Influence): This item focuses on the tendency of the child to follow the lead of peers regardless of danger or appropriateness.

- ⑤ *Minimal Difficulty* – Can avoid negative peer influence with effort

At level the child's tendency to follow the lead of peers in the neighborhood or the community is noticeable some of the time, but the child is able to control the tendency to do so with effort.

At level ⑤ the child's tendency to follow the lead of peers in the neighborhood or the community is more consistently present and recognized. The child is able to control the tendency to do so by exerting consistent vigilance and effort.

④ - ③ *Moderate Difficulty* – Moderates negative peer influence with extra effort and support

At level ④ the child can moderate her/his tendency to follow the lead of peers only with extra effort and support from others. The child takes an active role in the appropriate use of these supports to moderate the impact of the emotional disturbance of these peer influences.

At level ③ the child's tendency to follow the lead of peers is pervasive and likely to result in negative consequences without direct help from others. The support needed from others is welcomed by the child and is seen as necessary in order to moderate potential negative impact on the child.

② - ① *Severe Difficulty* – Cannot avoid negative peer influence without supervision

At level ② the child's ability to take responsibility for following the lead of peers in the neighborhood and the community appears to be beyond her/his control, but in realizing the negative consequences she/he will permit others to supervise or oversee these interactions very closely.

At level ① the child's ability to take responsibility for following the lead of peers in the neighborhood and the community is beyond her/his capability. The child may not see this as a problem and either resists any assistance by others or is so indifferent to any assistance that she/he exhibits no belief or understanding that any assistance could correct the problem.

***Factor I: Disruptive Behavior (Item 18 – Disruptive & Inappropriate Behavior)*:** This item focuses on behaviors that will typically bother others who witness the behavior. The behaviors also will lead to others either avoiding the child or attempting to control the child's behavior against the child's will. Under either condition, some degree of impairment to role performance or functioning (particularly in educational or social functioning) is evident.

- ⑤ *Minimal Difficulty* – Controls behavior with effort

At level the child exhibits some difficulty with controlling impulses, which is noticeable some of the time, but the child is able to control these impulses when there is any threat to impaired performance or functioning.

At level ⑤ difficulty with controlling impulses is more consistently present. To prevent noticeable impairment in role performance or functioning, the child exerts consistent vigilance and effort.

④ - ③ *Moderate Difficulty* – Controls behavior with extra effort and support

At level ④ difficulty with controlling impulses is noticeable to the child and others, but she/he can control behavior with extra effort and support from others.

At level ③ difficulty with controlling impulses is at a level that would lead to negative consequences without direct help from others. The support needed from others is welcomed by the child and is seen as necessary to perform day-to-day activities.

② - ① *Severe Difficulty* – Little or no control without supervision

At level ② controlling impulses is beyond the capability of the child, but the child recognizes the severity of the impact on role performance or functioning and will permit others to direct her/his activities very closely.

At level ① impulse control is beyond the capability of the child and she/he does not recognize the negative consequences of her/his behavior. The child either resists any assistance by others or is so indifferent to any assistance that she/he does not recognize that the intervention could correct the problem.

***Factor I: Disruptive Behavior (Item 19 – Risk or Criminal Behavior)*:** The child behaves in ways that lead to getting hurt or into trouble, or to involvement with the criminal justice system.

- ⑤ *Minimal Difficulty* – Avoids risk or criminal behavior with effort

At level the child's difficulty with avoiding risk or criminal behavior is noticeable some of the time, but the child is able to control any threat to role performance or functioning.

At level ⑤ the child's difficulty with avoiding risk or criminal behavior is more consistently present. To prevent noticeable role performance or functional impairment the child exerts consistent vigilance and effort.

④ - ③ *Moderate Difficulty* – Avoids risk or criminal behavior with extra effort and support

At level ④ the child's difficulty with avoiding risk or criminal behavior is noticeable to self and others, and she/he recognizes the potential negative consequences if no control is exerted. The child exerts the appropriate level of control with extra effort *and* with some support from others.

At level ③ the child's difficulty with avoiding risk or criminal behavior is at a level that would lead to negative consequences without direct help from others. The support needed from others is welcomed by the child and is seen as necessary to avoid performing these activities. The need for external support by others is seen as more important here than at level ④.

② - ① *Severe Difficulty* – Does not avoid risk or criminal behavior without supervision

At level ② avoiding risk or criminal behavior is beyond the child's capability. The child does not appear able to take personal responsibility for the problem or its remediation, but does recognize that extreme negative consequences could result if no control is exerted. Thus, she/he will permit others to closely direct her/his activities.

At level ① avoiding risk or criminal behavior is beyond the capability of the child and there appears to be little recognition of the negative consequences of her/his actions. Moreover, the child either resists any assistance by others or is so indifferent to any assistance that she/he exhibits no belief or understanding that the intervention could remedy the problem.

***Factor J: Substance Use/Abuse (Item 20, 21 & 22), and Factor K: Tobacco Use (Item 23)*:** [Adapted from Drake, Teague, et al., 1990] – Separate ratings are provided for alcohol and drug(s) (Item **# 20**) and for tobacco (Item **#23**) for the last 30 days. Two additional ratings are requested regarding alcohol and drug use: Item **#21** *"Use over months 2 through 12,"* and Item **#22** *"Use over life time"* prior to the interview. The rating scale used for these ratings is given below. It combines problem severity with self-management.

Ratings must be age appropriate – It is obvious that there are markedly different baselines as to the severity levels that are related to the child's age. For example, weekend marijuana or alcohol use for a child 10 years and younger is potentially much more problematic than it is for a child 11 to 14 years and for a child 15 to 18 years of age. The general rule of thumb is that the severity of frequency and amount per occurrence of use is inversely related to the child's age – the younger the child, the more severe the rating for a given level of use. It is, of course, a clinician's judgment as to the rating of that severity level. Unfortunately, research and clinical literature does not provide any established rules on this topic. The scale described below focuses on role performance and functioning, and the adjustment of this scale to the child's age appropriate role performance and levels of functioning should be the best guide.

⑦ ***NONE****: The child has not used substance(s).*

- ⑤ *MILD-MINIMAL**: Used substance(s), but no evidence of persistent or recurrent social, educational/occupational, psychological, or physical problems related to use, no evidence of immediate dangerous use. The distinction between level and ⑤ is the ease with which the child can exert control over taking more than they should. At level the child recognizes the social and legal implications of substance use, recognizes her/his desire to use, but can readily exert the control necessary to avoid inappropriate use and related problems. [Note: If it is an illegal substance, this means avoiding any use.] At level ⑤, the person requires more vigilance to control her/his use of the substance(s).*

④ - ③ *MODERATE**: Used substance(s) with evidence of immediate or recurrent social, educational/occupational, psychological, or physical problems or evidence of recurrent or dangerous use. Moderate or intermittent signs of impairment on functioning. At level ④ the child recognizes the problem and requires considerable effort and support to control her/his substance use. At level ③ the child reports that the effort required to control her/his wanting to abuse is almost constant, and also that she/he needs ready access to support to sustain her/his efforts. Success in the control of use at both levels is less than perfect for some. Some report that they do not believe that they can sustain control without active involvement with a support system (see Item **#24. Reliance on Mental Health Services**).*

② ***SEVERE****: Meets **moderate** criteria **plus** current evidence of greater amounts or duration of consumption than intended; much time spent obtaining or using substance; current intoxication or withdrawal interfering with other activities; continued use despite knowledge of substance related problems; marked tolerance; withdrawal symptoms or use to relieve/avoid withdrawal. Although the child recognizes the extent of the problem, her/his ability to control intake without assistance from others does not appear to be possible.*

① ***EXTREME****: Meets **severe** criteria **plus** problems precipitating or exacerbating current crisis. The child does not appear to recognize the seriousness of the problem while at this level and will*

typically resist any assistance.

In addition to rating the problem severity over the last 30 days, the intensity of the substance use is assessed by more detailed questions with regard to:

Alcohol:

 # Drinks per week [one drink = one shot or one glass of wine or one 12-ounce beer]

$ per month (Optional) [Child's estimate of amount of money spent on alcohol over the last 30 days]

Drug(s):

# of Different Drugs used [in last 30 days]

$ per month (Optional) [Child's estimate of the amount of money spent on drugs over the last 30 days]

If there is evidence of alcohol or drug use currently or in the past, be sure that you re-check for any complications that may co-exist with the problem domains covered under:

#18. Disruptive & Inappropriate Behavior
#19. Risk or Criminal Behavior
#24. Reliance on Mental Health Services

Factor L: Reliance on Mental Health Services (Item 24):

The rating on this item is critical to service planning. Its focus is on the extent to which the child and/or the parent(s)/caregiver(s) can maintain the child's age appropriate role performance and/or functioning in the community with or without the agency's involvement. Thus, the rating could focus on the reliance on services of the child, or of the parent(s)/caregiver(s), or both. The narrative should specify who is the recipient of the services and why the services are needed.

It should be noted that a child or the parent(s)/caregiver(s) can receive ratings of levels ⑤ or throughout the other items of this instrument and still exhibit behaviors, or be under circumstances, that indicate a level of ④ or less on this item. The categories listed below the sample *probe question* provide possible reasons for the child or the parent(s)/caregiver(s) to receive services. If there has been a long history of mental health or addiction problems for the child and/or for the parent(s)/caregiver(s), this should also be noted, if not noted elsewhere. Obviously, the higher the rating of self-reliance, the more concrete the argument needs to be to justify that the person needs continued services. The focus of the rating can be either the child or the parent(s)/caregiver(s) or both. The accompanying narrative must identify what is the basis for the rating.

⑦ ***No Reliance on Services to Maintain Functioning in the Community***

At level ⑦, the services may enhance the child's functioning, but are not required to maintain community functioning.

- ⑤ *Minimal Reliance on Services* – Can manage activities with effort

At level the child will manifest some sub-optimal functioning in the community without services designed for the child or the parent(s)/caregiver(s) or both.

At level ⑤ the child will manifest mild difficulty in at least one major life area without services.

④ - ③ *Moderate Reliance on Services* – Can manage with extra effort and support

At level ④ the child will manifest moderate difficulty in at least one major life area, noticeable to self and others without services.

At level ③ the child will manifest moderate difficulty in more than one major life area with definite negative consequences without services.

② - ① *Severe - Total Reliance on Services* – Cannot manage without supervision or support

At level ② the child will manifest severe difficulty in at least one major life area such that danger to self or others appears to be imminent without services.

At level ① the child will manifest severe difficulty in multiple life areas such that danger to self or others appears to be imminent without services.

VI. Information Required on Face Sheet (Page 1 of the HAPI-C)

***Consumer IDs**:* The consumer ID is a 16-character alphanumeric identification number used by the Division of Mental Health (DMH) and should appear *at the top of page one*. Here are the step-by-step instructions for creating a correct consumer ID:

f	f	f	y	y	y	y	m	m	d	d	g	s	s	s	s

fff = first three letters of the first name. if less than three letters, fill with "/".
yyyymmdd = birth date (year/month/date)
g = gender ('M' or 'F')
ssss = last 4 digits of SSN, i.e., 123-45-6789 would be 6789

EXAMPLES:
Ed is a male, born 2/3/1954, and the last 4 digits of his SSN are 6789: ED/19540203M6789
Mary is a female born 7/4/1963, and the last 4 digits of her SSN are 5678:
MAR19630704F5678

***Type of Review* --** The last person to review the instrument for completeness prior to it being entered into the FSSA-DMH database is to indicate which type or types of review were provided. It is not required that all classes of review be performed, only that the type that was performed be documented.

The **review** categories are:

|___|-**Supervisory** – a review by a person in a supervisory position

|___|-**Peer** – a review by a peer, which might be done when a program is using a team approach

|___|-**Records** – a review by the records staff, sometimes this person will also provide the **DSM-IV** diagnostic information

|___|-**Other [name]**

FACTOR SCORE SUMMARY

There are 12 Factor Scores that are to be entered into the State Database (FACTOR A through FACTOR L) as they are listed on this page. Each Factor Score is the sum of the items within a Factor, as rated in the body of the instrument (pages 2 through 6 of the ***HAPI-C***). The instructions as to which items are to be summed for each Factor are given on page 1. Obviously, if there is just one item within a Factor then the single item's rating is entered as the Factor Score. To the immediate right of each Factor Name is a listing of the items to be summed. To the far right, in brackets, is a listing of the range of values that can occur.

AXIS-V [Global Assessment of Functioning]: This is Axis V for children of the *DSM-IV* (1994) multiaxial diagnosis.

Primary and Secondary Diagnoses of Record: Please use *DSM-IV* (1994) for these designations. This could be completed by a member of the medical records staff from other records, or another party (e.g., a physician).

PROBLEM SEVERITY & SELF-MANAGEMENT, & THEIR IMPACT ON FUNCTIONING

The Conceptual Framework for the Multi-Factor Scale Adapted for Children and Adolescents

The primary goal of MH services for children and adolescents is to assure the child's age-appropriate development in terms of how well the child and the family, with the help of available resources, can support and strengthen the child's development and to minimize distress to the child, the family, and to the larger community system. The definition of the levels for each of the items is detailed in the training manual. Each item seeks to estimate the degree to which two features of a problem area come together to impact the child's functioning. The first is the degree to which a particular problem or skill deficit impacts on a child's daily functioning; and second is the degree to which the problem is mitigated by her/his ability to self-manage her or his functioning and quality of life given the difficulties offered by the problem or skill deficit. Stated another way, a problem as described by its signs or symptoms might be quite severe, however, the child might also exhibit sufficient skills in managing the impact of that problem such that its impact on functioning or quality of life is lessened.

The general logic of self-management and its use when rating level of impairment or difficulty can be introduced by describing its extremes. When self-management is operating very well (with *minimal* problem difficulty or impact on functioning, levels or ⑤) the child is capable of monitoring her or his reaction to stressful situations and her/his own signs and symptoms. When these signs appear to be distressful and/or problematic to role functioning, the child makes use of available resources to mitigate the problem or negative influence on functioning. At the other extreme (level ①), the problem is so *severe* that the child either does not see it as a problem, or does not see that she/he has any responsibility for it, or does not think that anything can be done to alleviate the problem. In between these two extremes (*moderate levels*) are degrees to which the child becomes involved in taking responsibility for the problem and its impact on daily functioning.

The definition of the levels given within each item are different because the features of each problem and the self-management skills needed to deal with the problem are specific to that domain. The ratings on the ① to ⑦ scale should be made in terms of the definitions associated with each level. Then, either below the item or in the clinical narrative, one or more of the descriptors of specific features of the problem are to be identified, using the list below the sample *probe* question. If the listed problem features do not adequately describe the nature of the problem, then offer a brief note on this. The more explicit these notes are in terms of observed behaviors, the easier it will be to validate the ratings for communication and review purposes

Item #20-22 – Substance Abuse and Item #23 – Tobacco Use [Adapted from Drake, Teague, et al, 1990]

⑦ ***NONE****: The child has not used substance(s).*

- ⑤ ***MILD-MINIMAL****: Used substance, but no evidence of persistent or recurrent social, educational/occupational, psychological, or physical problems related to use, no evidence of immediate dangerous use. The distinction between level and ⑤ is the ease with which the child can exert control over taking more than they should. At level the child recognizes the social and legal implications of substance use, recognizes their wanting to use it, but can readily exert the control necessary to avoid inappropriate use and related problems. [Note: If it is an illegal substance, this means avoiding any use.] At level ⑤, the person requires more vigilance to control their use of the substance(s).*

④ - ③ ***MODERATE****: Used substance with evidence of immediate or recurrent social, educational/occupational, psychological, or physical problems or evidence of recurrent or dangerous use. Moderate or intermittent signs of impairment on functioning. At level ④ the child recognizes the problem and requires considerable effort and support to control her/his substance use. At level ③ the child would report that the effort required to control her/his wanting to abuse is almost constant, and also that she/he needs ready access to support to sustain her/his efforts. Success in the control of use at both levels is less than perfect for some. Some report that they do not believe that they can sustain control without active involvement with a support system (see Item* ***#24. Reliance on Mental Health Services****).*

② ***SEVERE****: Meets* ***MODERATE*** *criteria plus current evidence of greater amounts or duration of consumption than intended; much time spent obtaining or using substance, current intoxication or withdrawal interfering with other activities due to use; continued use despite knowledge of substance related problems, marked tolerance; withdrawal symptoms or use to relieve/avoid withdrawal. Although the child recognizes the extent of the problem, ability to control intake without assistance from others does not appear to be possible.*

① ***EXTREME****: Meets* ***SEVERE*** *criteria - plus problems precipitating or exacerbating current crisis. The child does not appear to recognize the seriousness of the problem while at this level and will typically resist any assistance.*